DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056109	A. BUILDING ____ B. WING ____	C 11/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND SKILLED NURSING FACILITY	678 THIRD STREET WOODLAND, CA 95695

acceptable POC 12/26/18

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated survey for the investigation of two (2) complaints #CA00597479 and #CA00597496. Representing the Department of Public Health: HFEN, 29108 The inspection was limited to the specific complaints investigated and does not represent the findings of a full inspection of the facility.	F 000	Preparation and/or correction of this plan of correction does not constitute admission of agreement by the Provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by Provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907	
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including	F 622	11/12/18 **F 622 CFR(s): 483.15© Transfer Discharge-483.15(c)(1)(i)(ii)(2)(i)-(iii)** **How corrective action(s) will be accomplished for those found to have been affected by the deficient practice:** >Resident 1 no longer resides at the facility. **How the facility will identify other Residents having the potential to be affected by the**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 12/11/18

Revised POC 12/11/18 on behalf of James Ellis Admin

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056109	A. BUILDING _____ B. WING _____	C 11/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND SKILLED NURSING FACILITY	678 THIRD STREET WOODLAND, CA 95695

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 1 Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-	F 622	**same practice and what corrective actions will be taken;** All residents could be potentially affected. >The facility conducted a retrospective review of discharged residents for the month of July 2018. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur;** >The DNS and/or designee will review the facility's Discharge policy with the new physician group managing resident care to ensure ongoing compliance and documentation regarding resident transfer and/or discharge in the medical record. >The DNS, Medical Records Director, and Medical Records Consultant will modify the existing discharge summary form as part of the performance improvement plan	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056109	A. BUILDING _____ B. WING _____	C 11/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND SKILLED NURSING FACILITY	678 THIRD STREET WOODLAND, CA 95695

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 2 (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure Resident 1's physician documented the transfer or discharge in the medical record. This led to a failure in communicating the appropriate information to the receiving health care institution and provider. Findings: According to the medical record, Resident 1 was admitted to the facility on 7/4/18 with diagnoses including myocardial infarction (heart attack) and dementia. Resident 1 was transferred/discharged back to the hospital from where he was admitted	F 622	(PIP) to facilitate communication with the receiving health care institution and provider. The physicians" will receive individual 1:1 in-service regarding the new form. **How the facility plans to monitor its performance to make sure that solutions are sustained;** Medical records will continue to audit 100% of DC records per facility policy (e.g., prior to 30-days post DC) to ensure completion of required documentation. The DNS will also evaluate audit findings monthly to identify any trends. The desired initial transfer discharge documentation compliance threshold is 95 percent. Compliance findings will be presented at the next quarterly QAPI meeting. Audits will be ongoing per facility policy. In addition, the DNS and/or Medical Records Director will audit the new DC summary PIP for effectiveness, achievement of	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056109	A. BUILDING _____ B. WING _____	C 11/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND SKILLED NURSING FACILITY	678 THIRD STREET WOODLAND, CA 95695

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 3 due to unsafe and aggressive behaviors on 7/30/18. A copy of the Notice of Proposed Transfer/Discharge sent to Resident 1's son, dated 7/30/18, was reviewed. It read: "Dear [Resident 1's] son, As per the admission agreement, the facility shall transfer/discharge a resident when the facility determines that such action is appropriate in order to meet the resident's needs for health care services. This is to inform you that [Resident 1] will be transferred/discharged to [hospital name] on 7/30/18 for the following reason(s): 1. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility. 2. The safety of the individuals in the facility would be endangered by the resident being here. 3. The health of individuals in the facility would be endangered by the resident being here. [and] 4. The resident has not resided in the facility for 30 days." The letter was signed and dated by the Administrator on 7/30/18. Further review of Resident 1's medical record revealed the absence of physician notes documenting the basis for the transfer, the specific resident needs that could not be met, the facility's attempts to meet his needs, and the service(s) available at the receiving facility to meet those need(s). In an phone interview with the Medical Records Director (MRD) on 9/14/18 at 12:35 a.m., the MRD confirmed that the only physician notes in Resident 1's medical record was an Admission History and Physical, dated 7/6/18, and the incomplete discharge summary. Neither of these	F 622	desired 95 percent compliance threshold, and present the findings at the next quarterly QAPI meeting. The QAPI committee will make a determination as to the frequency of the ongoing monitoring for compliance based on the outcome of the reviews. The date when corrective action will be completed: **12/10/18** **F 661 Discharge Summary CFR(s) 483.21©(2)(i)-(iv)** **How corrective action(s) will be accomplished for those found to have been affected by the deficient practice:** >Resident 1 no longer resides at the facility. **How the facility will identify other Residents having the potential to be affected by the same practice and what corrective actions will be taken;**	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056109	A. BUILDING _____ B. WING _____	C 11/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND SKILLED NURSING FACILITY	678 THIRD STREET WOODLAND, CA 95695

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 4 included the required transfer or discharge physician documentation. According to a 2017 facility policy titled, "Discharge Plan and Post Discharge Plan of Care", "The physician shall review the resident's progress and determine a possible discharge date. There shall be a physician order for discharge and the reason for the discharge...All discharge planning shall be documented in the medical record."	F 622	All residents could be potentially affected by this practice. >The facility conducted a retrospective review of discharged residents for the month of July 2018. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur;** >The DNS and/or designee will review the facility's Discharge policy with the new physician group managing resident care to ensure ongoing compliance and completion of the discharge summary per regulatory requirement. >The DNS, Medical Records Director, and Medical Records Consultant will modify the existing discharge summary form as part of the performance improvement plan (PIP). The physicians will receive individual 1:1 in-service regarding the new DC summary form.	
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where	F 661		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056109	A. BUILDING _____ B. WING _____	C 11/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND SKILLED NURSING FACILITY	678 THIRD STREET WOODLAND, CA 95695

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 5 the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to complete a discharge summary for Resident 1 that included a recapitulation and final summary of the resident's status, a reconciliation of all medications and a post-discharge plan of care. This failure to ensure that necessary information regarding Resident 1 was communicated in the mandated form of a complete, accurate and timely discharge summary put Resident 1 at risk for delayed, inaccurate and/or incomplete care post-discharge. Findings: According to a review of the medical record, Resident 1 was admitted to the facility on 7/4/18 with diagnoses including myocardial infarction (heart attack) and dementia. A Social Service Assessment, completed 7/4/18, revealed Resident 1 was admitted for "short term" "rehab" with the possibility of discharge. The Social Service Assessment indicated the "anticipated referrals needed (subject to treatment and diagnosis) included home health, nursing, physical therapy, occupational therapy, social work..." A "Social Service Progress Note", written 7/25/18, indicated that the Social Services Designee (SSD) called four alternative nursing facilities in which to transfer Resident 1. On 7/26/18, the SSD entered a progress note	F 661	**How the facility plans to monitor its performance to make sure that solutions are sustained;** Medical Director and/or designee will audit 100% of resident discharge records, including the modified discharge summary form, per facility policy. Audit findings, including completion of the modified discharge summary form, will also be reviewed by the DNS to determine compliance. Identified trends will be reviewed and addressed by the PIP committee (i.e. DNS, Medical Records Director, and Medical Record Consultant) monthly. The desired compliance threshold is 95 percent. Findings will be presented at the quarterly QAPI meetings to evaluate effectiveness and sustained compliance. The QAPI committee will make a determination as to the frequency of the ongoing monitoring for	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056109	A. BUILDING _____ B. WING _____	C 11/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND SKILLED NURSING FACILITY	678 THIRD STREET WOODLAND, CA 95695

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 6 indicating she called a facility requesting a bed for Resident 1. A final Social Service Progress Note was written 7/27/18 and read, "[Resident 1's son] gave permission to "fax referrals to any facility that is more appropriate. SSD explained that referrals would be sent out first thing Monday 7/30/18..." In an interview with the SSD on 8/1/18 at 9:55 a.m., she explained that on Monday 7/30/18, due to Resident 1's unsafe and aggressive behaviors, Resident 1's son (Resident 1's responsible party) was called by the Administrator, the SSD said, and was told he could either pick up his father at the facility or "we can send him with transportation" to the hospital from where he was admitted. The SSD stated, the facility sent Resident 1 to the hospital to meet his son via non-emergency transportation. The July 2018 Physician Orders for Resident 1 were reviewed. On 7/30/18, a physician order was received by nursing and documented as, "May transfer resident to [general acute care facility] to meet son [name]." During an interview with Director of Staff Development (DSD) on 7/31/18 at 3:30 p.m., copies of Resident 1's medical records, including the discharge summary, were requested. On 8/1/18 at 9:45 a.m., the DSD stated the discharge summary for Resident 1 was not yet completed. A second request for Resident 1's discharge summary was made during a phone interview with the Administrator on 9/12/18 at 9:30 a.m. The Department received a facsimile of Resident 1's discharge summary on 9/12/18. Resident 1's "Physician's Discharge Summary"	F 661	compliance based on the outcome of the reviews. The date when corrective action will be completed: 12/10/18	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056109	A. BUILDING _____ B. WING _____	C 11/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND SKILLED NURSING FACILITY	678 THIRD STREET WOODLAND, CA 95695

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 7 was reviewed. The discharge summary included the following information: Resident 1's admission date, discharge date, disposition, rehabilitation potential and admission diagnoses. The discharge summary was signed and dated by the facility's Medical Director (and Resident 1's attending physician) on 7/31/18. The following areas of the discharge summary were left incomplete: discharge diagnosis, summary of care, and prognosis. The discharge summary did not have a recapitulation or final summary of the resident's status, a reconciliation of all medications or a post-discharge plan of care. According to a 2017 facility policy titled, "Discharge Plan and Post Discharge Plan of Care", "[A] Discharge Summary shall include a recapituation of the resident's stay and a final summary of the resident's status...At a minimum, the discharge summary will contain a summary of the resident's status to include a description of the resident's:...medical status measurements,...physical and mental functional status,...and drug therapy..." In a phone interview with the Medical Records Director (MRD) on 9/14/18 at 12:35 a.m., the MRD acknowledged that Resident 1's discharge summary was limited to the one page facsimile she sent the Department.	F 661		